**Caring Transitions**

By James Lett II, MD, CMD

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**Decision Guide Helps Families Navigate Path From Home to Hospitalization**

It has occurred to every PA/LTC clinician on call, whether it’s a nurse practitioner, physician assistant, or physician. The skilled nursing facility calls with an acute change in status for a resident under your care. Fortunately, the nurse is well versed in AMDA’s Know-It-All series “When You’re Called Diagnosing System” and presents good, actionable information. The diagnosis appears clear. On-site intervention is appropriate, and you quickly formulate how to best intervene. You provide the nurse with a concise set of orders for care that would make even William Osler, MD, smile approvingly.

Chalk up another success for clinical care in the PA/LTC realm. Then it comes: “But, the family wants her to go to the hospital.” Few clinicians will refuse ED transfer in such instances. Three things then occur in rapid succession:

1. You fight to stifle a primal scream as to why the whole call took place before being notified of the family intent.
2. You grind your teeth down to the gums.
3. You give the order: “Send her to the hospital.” (Or alternatively and preferably, if you are a dedicated PA/LTC clinician, perhaps you take the time to contact the family to discuss the option of treating their loved one in-house.)

It is unknown how often family wishes drive hospital transfers. Anecdotally, in discussions among PA/LTC peers, it appears to happen regularly, but not frequently. Also experientially, it seems to occur in those most frail patients with end-stage chronic disease or advanced dementia. Thus, this pattern affects those least likely to benefit from aggressive intervention and long ED waits among the bright lights, unfamiliar clinicians, potentially inappropriate medications and restrained chaos present there.

**Family Matters**

Interesting insight into this complex decision-making process has come from a group at Florida Atlantic University (FAU). Ruth Tappen, EdD, RN, FAAN, and her team published an article in the Oct. 2014 issue of the *Journal of Gerontological Nursing* entitled “Remaining in the Nursing Home Versus Transfer to Acute Care: Resident, Family, and Staff Preferences” (Gerontol Nurs 2014;40(10):48-57). They reported that resident and family insistence to transfer a resident for an acute change in condition is a major factor in the potentially avoidable transfers from nursing homes to acute care.

Their interviews revealed that most residents and families simply had not considered the prospect of being transferred from the nursing home to the acute hospital, and were unprepared for such a critical and immediate decision. Additionally, the terminology involved in acute changes in clinical status, the transition process, and advance directives (e.g., “hospitalist,” “DNR,” “living will”) generally was not familiar to them. Residents more often thought they should be fully involved in the transfer decision than did their family members or staff. Facility staff preferred keeping residents in the nursing home for care, if possible. It was also determined that the clinician should expect ethnic differences in perceptions of this process. The authors further cautioned that the skilled nursing facility practitioner should expect resistance to reduce unnecessary hospitalizations and long ED waits among the residents, family, and providers to have different perspectives regarding a return to the hospital.

Based upon their interviews of residents, family members and care providers, the group developed a decision guide for residents and families. Entitled “Go To the Hospital or Stay Here? A Decision Guide for Patients and Families,” it is available in English and Spanish at the FAU website (http://nursing.fau.edu/index.php/main-6&nav=979) at no cost. The guide discusses changes in condition, why a conversation about returning to the hospital should be had early in the SNF stay, reasons to prefer being treated in the facility vs. the hospital, risks of going to the hospital, and being involved in the decision as the resident, among other topics.

Further helpful sections provide information for families with cognitively impaired residents—along with frequently asked questions—followed by a decision tree about going to the hospital. Comments from the interviews with residents, families, and care providers are included. Like other tools, it is not designed to substitute for in-depth, interactive discussions among clinicians and residents and/or families, but it is a supplement to those interactions.

This study and the resulting decision guide offer several opportunities for improving care and reducing hospital admissions and readmissions.

**Mixed Messages**

The prospect of having an acute problem possibly necessitating a transfer to the hospital is uppermost in the minds of clinicians, and we incorrectly assume it is also foremost in the minds of the resident and family. It is not. Early conversations regarding the consideration of hospital transitions—incorporating the benefits and risks of treatment onsite in the facility vs. transfer to the hospital—are essential. If the first interaction on this subject occurs at 2 a.m. when the resident has an acute change in status, the clinician can be sure an acute transfer will follow.

Demystify the language involved in advance directive and hospital transfer discussions. Use clear, consistent language to determine the wishes of the resident regarding end-of-life, including whether transfer to the acute facility is desired. It is important to document those wishes, inform the family of the patient decisions on the subject of transfers (with resident permission), and then respect them.

In the study, residents reported they should be more fully involved in their transfer decisions. Given the rapid-pace events in acute changes in condition, resident engagement remains paramount.

Keep the resident informed in all clinical progress updates. Rarely is transfer to the hospital a binary, yes/no, decision. The study indicated that residents are prone to make transfer decisions based upon the severity of their condition and their prognosis. Without adequate data, no informed decision can be expected.

Bearing in mind that facility staff prefer to keep residents on site for care when appropriate, rather than transitioning them to the hospital, tap into that positive inclination. Work to expand the treatments available in the facility and upgrade skills.

The FAU decision guide offers assistance to reduce unnecessary hospital admissions and readmissions for the PA/LTC clinician. It can be used upon nursing home admission to introduce the subject of returns to the hospital and advance directives. Or, leave it after the first conversation with the resident and family for their further information.

Typically, they are so stunned by the entire process of illness, hospitalization, and now nursing home readiness, that the subject of returning to the hospital is the furthest thing from their minds. This offers the PA/LTC clinician one more tool to meet patient and family needs, advocate for patient wishes, and address unnecessary hospitalizations and re-hospitalizations.

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**Conference Fellow Opportunity Announced**

The Caring for the Frail Elderly Conference will take place Aug. 19-20, 2016 in Columbia, MO. The conference attracts nearly 300 professionals from around the state, including primary care physicians, nurse practitioners, nurses, nursing home administrators, physical and occupational therapists, state surveyors, social workers, and others.

This year, graduate and professional students may apply for a position as a Conference Fellow. Selected Fellows will have their registration fee waived, opportunities to present, and the chance to dine with the keynote speaker and other geriatric professionals.

This position is open to graduate and professional students who demonstrate interest in the care of the aging population and advancing knowledge to improve the well-being of older adults. For more information, visit the website at http://medicine.missouri.edu/cfe/.

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A past AMDA president, Dr. Lett chaired the AMDA workgroup that created the clinical practice guideline “Care Transitions in the Long-term Care Continuum” and currently is chair of the AMDA Transitions of Care Committee. Read this and other columns at www.caringfortheages.com under “Columns.”